Hudson Highlands Dentistry LLC
JOHN T. LYNCH, DMD

welcome

Date _____

Patient's Name _____ (Last) _____ (First) ____ (Initial) Date of Birth _____ Age _____ ❑ Male ❑ Female

If Child: Parent's Name _____

How do you wish to be addressed _____
Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Minor ❑

Residence - Street _____

City _____ State ____ Zip _____

Business Address _____

Telephone: Res. _____ Bus _____

Fax _____ Cell Phone # _____

eMail _____

Patient/Parent Employed By _____

Present Position _____

How Long Held _____

Spouse/Parent Name _____

Spouse Employed By _____

Present Position _____

How Long Held _____

Who is Responsible for this account _____

Drivers License No. _____

Method of Payment Insurance ❑ Cash ❑ Credit Card ❑

Purpose of Call _____

Other Family Members in this Practice _____

Whom may we thank for this referral _____

Patient/parent Social Security No. _____

Spouse/Parent Social Security No. _____

Someone to notify in case of emergency not living with you

Dental Insurance 1st Coverage

Employee Name _____ Date of Birth _____
Employer Name _____ Yrs. _____
Name of Insurance Co. _____
Address _____
City _____ State ____ Zip _____
Telephone _____
Program or policy # _____
Social Security No _____
Union Local or Group _____

Dental Insurance 2nd Coverage

Employee Name _____ Date of Birth _____
Employer Name _____ Yrs. _____
Name of Insurance Co. _____
Address _____
City _____ State ____ Zip _____
Telephone _____
Program or policy # _____
Social Security No. _____
Union Local or Group _____

CONSENT:
I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my card (or my child's card) or payment for that care.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in pad by my dental care payor.
I attest to the accuracy of the information on this page.

PATIENTS OR GUARDIAN'S SIGNATURE

DATE _____

Form No. TI1OR

REGISTRATION

welcome

Hudson Highlands Dentistry LLC
JOHN T. LYNCH, DMD

(800) 243-4675

Patient's Name _____ (Last) _____ (First) _____ (Initial) _____ (Date of Birth)

1. Purpose of initial visit _____
2. Are you aware of a problem? _____
3. How long since your last dental visit? _____
4. What was done at that time? _____
5. Previous dentist's name _____
   Address: _____ Tel. _____
6. When was the last time your teeth were cleaned? _____

CLICK THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

7. Have you made regular visits? ❒ YES ❒ NO
   How often: _____
8. Were dental x-rays taken? ❒ YES ❒ NO
9. Have you lost any teeth or have any teeth been removed? ❒ YES ❒ NO
   Why? _____
10. Have they been replaced? ❒ YES ❒ NO
11. How have they been replaced?
    a. Fixed bridge _____ Age _____
    b. Removable bridge _____ Age _____
    c. Denture _____ Age _____
    c. Implant _____ Age _____
12. Are you unhappy with the replacement? ❒ YES ❒ NO
    If yes, explain _____
13. Would you like to know about permanent replacements? ❒ YES ❒ NO
14. Have you ever had any problems or complications with previous dental treatment? ❒ YES ❒ NO
    If yes, explain: _____
15. Do you clench or grind your teeth? ❒ YES ❒ NO
16. Does your jaw click or pop? ❒ YES ❒ NO
17. Have you experienced any pain or soreness in the muscles or your face or around your ear? ❒ YES ❒ NO
18. Do you have frequent headaches, neckaches or shoulder aches? ❒ YES ❒ NO
19. Does food get caught in your teeth? ❒ YES ❒ NO
20. Are any of your teeth sensitive to: ❒ Hot? ❒ Cold? ❒ Sweets? ❒ Pressure?
21. Do your gums bleed or hurt? ❒ YES ❒ NO
    When? _____
22. How often do you brush your teeth? _____ When? _____
23. Do you use dental floss? ❒ YES ❒ NO
    How often? _____
24. Are any of your teeth loose, tipped, shifted or chipped? ❒ YES ❒ NO
25. Are you unhappy with the appearance of your teeth? ❒ YES ❒ NO
26. How do you feel about your teeth in general? _____
27. Do you feel your breath is offensive at times? ❒ YES ❒ NO
28. Have you ever had gum treatment or surgery? ❒ YES ❒ NO
    What? _____
    Where? _____
    When? _____
29. Have you had any orthodontic work? _____
30. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? _____
31. Do you have any questions or concerns? ❒ YES ❒ NO

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

DENTAL HISTORY

MED.ALERT

welcome

Hudson Highlands Dentistry LLC
JOHN T. LYNCH, DMD

Patient's Name _____ _____ _____ _____
Last First Initial Date of Birth

CHECK THE APPROPRIATE ANSWER, IF YOU DON'T KNOW THE CORRECT ANSWER PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION

1. Physician's Name _____
   Address _____
   _____ Tel _____
2. Are you under a physician's care? ❒YES ❒NO
   Since when _____ Why _____
3. When was your last complete physical exam? _____
4. Are you taking any medication or substances? ❒YES ❒NO
   (if yes, please list medications in comments section.)
5. Do you routinely take health related substances? (Vitamins, herbal supplements, natural products) ❒YES ❒NO
6. Are you allergic to any medications or substances? (please list) ❒YES ❒NO
7. Do you have any other allergies or hives? ❒YES ❒NO
8. Do you have any problems with penicillin, antibiotics, anesthetics or other medications? ❒YES ❒NO
9. Are you sensitive to any metals or latex? ❒YES ❒NO
10. Are you pregnant or suspect you may be? ❒YES ❒NO
11. Do you use any birth control medications? ❒YES ❒NO
12. Have you ever been treated for or been told you might have heart disease? ❒YES ❒NO
13. Do you have a pacemaker or an artificial heart valve implant, or been diagnosed with mitral valve prolapse? ❒YES ❒NO
14. Have you ever had rheumatic fever? ❒YES ❒NO
15. Are you aware of any heart murmurs? ❒YES ❒NO
16. Do you have ❒high or ❒low blood pressure? (please check) ❒YES ❒NO
17. Have you ever had a serious illness or major surgery? ❒YES ❒NO
    If so, explain _____
18. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition? ❒YES ❒NO
19. Do you have inflammatory diseases, such as arthritis or rheumatism? ❒YES ❒NO
20. Do you have any artificial joints/prosthesis? ❒YES ❒NO
21. Do you have any blood disorders, such as anemia, leukemia, etc? ❒YES ❒NO
22. Have you ever bled excessively after being cut or injured? ❒YES ❒NO
23. Do you have any stomach problems? ❒YES ❒NO
24. Do you have any kidney problems? ❒YES ❒NO
25. Do you have any liver problems? ❒YES ❒NO
26. Are you diabetic? ❒YES ❒NO
27. Do you have fainting or dizzy spells? ❒YES ❒NO
28. Do you have asthma? ❒YES ❒NO
29. Do you have epilepsy or seizure disorders? ❒YES ❒NO
30. Do you or have you had venereal disease? ❒YES ❒NO
31. Have you tested HIV positive? ❒YES ❒NO
32. Do you have AIDS? ❒YES ❒NO
33. Have you had or do you test positive for hepatitis? ❒YES ❒NO
34. Do you or have you had T.B.? ❒YES ❒NO
35. Do you smoke, chew, use snuff or any other forms of tobacco? ❒YES ❒NO
36. Do you regularly consume more than one or two alcoholic beverages a day? ❒YES ❒NO
37. Do you habitually use controlled substances? ❒YES ❒NO
38. Have you had psychiatric treatment? ❒YES ❒NO
39. Have you taken any prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products? ❒YES ❒NO
40. Do you have any disease condition, or problem not listed? If so, explain
    _____
41. Is there anything else we should know about your health that we have not covered in this form?
    _____
42. Would you like to speak to the Doctor privately about any problem? ❒YES ❒NO

COMMENTS

43. Have you ever take Fosamax, Zometa, Aredia, or any other oral or intravenous treatment (bisphosphonates) for bone tumors, excessive calicum in your blood or osteoporosis? ❒YES ❒NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MEDICAL HISTORY

MED.ALERT

Hudson Highlands Dentistry LLC
JOHN T. LYNCH, DMD

Wisconsin Dental Association
(800) 243-4675

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

Federal and state law requires us to maintain the privacy of your health information. That law also requires us to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices we describe in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such applicable law permits the changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and health care operations. For example:
Treatment: We may use your health information for treatment or disclose it to a dentist, physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

Health Care Operations: We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

On Your Authorization: You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

Disaster Relief: We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law;
- for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- to report adult abuse, neglect, or domestic violence;

- to health oversight agencies;
- in response to court and administrative orders and other lawful processes;
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- to coroners, medical examiners, and funeral directors;
- to an organ procurement organizations;
- to avert a serious threat to health or safety;
- in connection with certain research activities;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates; and
- as authorized by state worker's compensation laws.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying costs, and postage. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we may-but are not required to-prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for more information about fees.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years (but not before April 14, 2003). That list will not include disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for more information about fees.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. You must specify in your request the alternative means or location, and provide satisfactory explanation how you will handle payment under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why we should amend the information. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.
If you believe that:

- we may have violated your privacy rights,
- we made a decision about access to your health information incorrectly,
- our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect, or
- we should communicate with you by alternative means or at alternative locations,

you may contact us using the information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.
We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Provider Contact Office: Tammy Scott

Telephone: (845) 343-6908 Fax: (845) 343-5850

E-Mail: office@JohnLynchDMD.com

Address: 22 Mulberry Street, Middletown, New York 10940

Hudson Highlands Dentistry LLC
JOHN T. LYNCH, DMD

SECTION A: The Patient.

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: Acknowledgement of Receipt of Privacy Practices Notice.

I _____ , acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature: _____ Date: _____

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

SECTION C: Good Faith Effort to Obtain Acknowledgement of Receipt. Office Use Only

Describe your good faith effort to obtain the individual's signature on this form:

_____

_____

_____

Describe the reason why the individual would not sign this form:

_____

_____

_____

SIGNATURE:

I attest that the above information is correct.

Signature: _____ Date: _____

Print name: _____ Title: _____

Include this acknowledgement of receipt in *the* individual's *records.*

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

From No. T303HA

Hudson Highlands Dentistry LLC
JOHN T. LYNCH, DMD

ADULT PHOTOGRAPHIC RELEASE

Photographs can be used in many ways in our office. We use them on our website as an educational tool to help patients see examples of different types of treatment. They can be used in the office in talking to patients for the same purpose. Potentially, they could be used in advertising. Almost all of the photographs are of your mouth or x-ray images. This release is for those types of images. If ever we need to use an image that will show your face so that you may be recognized by others, we will specifically ask you for permission before using that image.

In consideration of my engagement as a model, upon the terms herewith stated, I hereby give to Hudson Highlands Dentistry, LLC (photographer), its heirs, legal representatives and assigns, those for whom (photographer) is acting, and those acting with its authority and permission:

a) The unrestricted right and permission to copyright and use, re-use, publish, and republish photographic portraits or pictures of me or in which I may be included intact or in part, composite or distorted in character or form, without restriction as to changes or transformations in conjunction with my own or a fictitious name, or reproduction hereof in color or otherwise, made through any and all media now or hereafter known for illustration, art, promotion, advertising, trade, or any other purpose whatsoever.

b) I also permit the use of any printed material in connection therewith.

c) I hereby relinquish any right that I may have to examine or approve the completed product or products or the advertising copy or printed matter that may be used in conjunction therewith or the use to which it may be applied.

d) I hereby release, discharge and agree to hold harmless (photographer), its heirs legal representatives or assigns, and all persons functioning under its permission or authority, or those for whom its is functioning, from any liability by virtue of any blurring, distortion, alteration, optical illusion, or use in composite form whether intentional or otherwise, that may occur or be produced in the taking of said picture or in any subsequent processing thereof, as well as any publication thereof, including without limitation any claims for libel or invasion of privacy.

e) I hereby affirm that I am over the age of majority and have the right to contract in my own name. I have read the above authorization, release and agreement, prior to its execution; I fully understand the contents thereof. This agreement shall be binding upon me and my heirs, legal representatives and assigns.

Date: _____ Signature: _____

Name: _____

Address: _____

City: _____State/Zip: _____

Phone: _____

Witness: _____

Hudson Highlands Dentistry LLC
JOHN T. LYNCH, DMD

22 Mulberry Street
Middletown, NY 10940
(845) 343-6908
office@JohnLynchDMD.com

PATIENT RECORDS ACCESS REQUEST FORM

I hereby request a copy of the dental record and x-rays to be released from:

_____

_____

_____

_____

Patient Name: _____

Date of Birth: _____

Name (if Parent or Guardian): _____

Relationship: _____

Signature: (Patient or Parent / Guardian) _____

Date: _____

Office Use Only

Date Sent _____

Initial of clerk _____

Please return a copy of this request along with the dental record and x-rays to our office at your earliest convenience. Thank you for your prompt attention to this request.